Provided By Heffernan Insurance Brokers

Employment Law Summary

Missouri

HEFFERNAN INSURANCE BROKERS

Because You're Different

Health Insurance Mandates

State health insurance mandates are laws regulating the terms of coverage for insured health plans. Mandates can affect various parts of health insurance plans, as follows:

- **Benefit mandates** require health insurance plans to cover specific treatments, services or procedures. In some cases, however, benefit mandates require issuers to *offer coverage* for specific treatments, services or procedures to employers for purchase.
- **Provider mandates** require health insurance plans to pay for services provided by specific health care professionals. Often, provider mandates are in the form *of nondiscrimination mandates* that require coverage only if the health plan already reimburses services within the scope of the health care professional's practice.
- **Person mandates** require health insurance plans to cover specific categories of people.

Additional mandates for health plans exist at the federal level. For example, the Affordable Care Act (ACA) requires non-grandfathered plans in the small group and individual markets to provide coverage for items and services designated as "essential health benefits." Health plan sponsors and issuers should work with their advisors to determine how to comply with applicable federal and state mandates.

This Employment Law Summary contains charts outlining Missouri's benefit, provider and person mandates for group health insurance policies. Please keep in mind that this summary of state insurance mandates does not address federal benefit mandates, such as those in the ACA.

State Resources

- **Missouri Department of Insurance:** https://insurance.mo.gov
- **Health Insurance Mandates:** A summary of health insurance mandates in Missouri, provided by the Department of Insurance
- **FAQs on Missouri's Autism Insurance Law:** https://insurance.mo.gov/consumers/autismFAQ/index.php

Benefit Mandates

MANDATE	DESCRIPTION
Autism spectrum disorder and developmental disabilities	Coverage for the diagnosis and treatment of autism spectrum disorders and for the diagnosis and treatment of developmental or physical disabilities (to the extent that this diagnosis and treatment is not already covered by the plan). This coverage cannot be subject to any greater deductible, coinsurance or copayment than other physical health care services provided by the plan. A "developmental or physical disability" is a severe chronic disability that: • Is attributable to cerebral palsy, epilepsy or any other condition other than mental illness or autism spectrum disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services; • Manifests before the individual reaches **age 19**; • Is likely to continue indefinitely; and • Results in substantial functional limitations in three or more areas of major life activities. Coverage for applied behavior analysis is subject to a maximum benefit of **$55,667** (as adjusted for inflation) per calendar year for individuals through **18 years of age**. This maximum benefit limit may be exceeded, upon prior approval by the plan, if the provision of applied behavior analysis services beyond the maximum limit is medically necessary for the individual. Coverage for therapeutic care provided for developmental or physical disabilities may be limited to a number of visits per calendar year, provided that upon prior approval by the plan, coverage must be provided beyond the limit if the therapeutic care is medically necessary.
Bone marrow transplants – human leukocyte antigen testing	Coverage for the cost for human leukocyte antigen testing (also referred to as histocompatibility locus antigen testing) for A, B and DR antigens for bone marrow transplants. Each enrollee may be limited to one testing per lifetime to be reimbursed at a cost of no greater than $75 by the plan. This coverage cannot be subject to any greater deductible or copayment than other similar health care services provided by the plan.
Breast cancer treatment *Required offer of coverage*	Issuers must *offer coverage* for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants. This coverage cannot be subject to any greater deductible or copayment than any other health care service provided by the plan, except that the plan may impose a lifetime benefit maximum of not less than **$100,000**, for dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for breast cancer treatment.
Cancer clinical trials – routine patient care	Coverage for routine patient care costs incurred as the result of phase II, III or IV of a clinical trial that is undertaken for the purposes of the prevention, early detection or treatment of cancer. Plans must also cover routine patient care costs incurred for drugs

MANDATE	DESCRIPTION
	and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial.
Cancer diagnosis – second opinion	Coverage for a second opinion rendered by a specialist in a specific cancer diagnosis area when a patient with a newly diagnosed cancer is referred to the specialist by his or her attending physician. This coverage must be subject to the same deductible and coinsurance conditions applied to other specialist referrals and all other terms and conditions applicable to other benefits.
Cancer screenings	Coverage for the following cancer screenings (in accordance with current American Cancer Society guidelines): • A pelvic examination and pap smear for any nonsymptomatic woman; • A prostate examination and laboratory tests for cancer for any nonsymptomatic man; and • A colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic person. This coverage must be at least as favorable and subject to the same dollar limits, deductible and copayments as other covered benefits or services.
Child health supervision services *Required offer of coverage*	Policies that provide family coverage must *offer coverage* for child health supervision services from **birth through age 12**. This coverage includes the periodic review of a child's physical and emotional status by a physician (or pursuant to a physician's supervision). Benefits must be provided at approximately the following age intervals: birth, two months, four months, six months, nine months, 12 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years and 12 years. This coverage must be subject to the same durational limits, dollar limits, deductibles and coinsurance factors as other covered services under the plan.
Chiropractic care	Coverage for chiropractic care delivered by a licensed chiropractor acting within the scope of his or her practice, including the initial diagnosis and clinically appropriate and medically necessary services and supplies required to treat the diagnosed disorder, subject to the terms and conditions of the plan. An enrollee may access chiropractic care within the plan's network for a total of 26 chiropractic physician office visits per policy period, but may be required to provide the plan with notice prior to any additional visit as a condition of coverage. Plans cannot establish any rate, term or condition that places a greater financial burden on an insured for access to treatment for a chiropractic care condition than for access to treatment for another physical health condition.
Chiropractic services – copayment cap	Plans cannot impose any copayment that exceeds 50% of the total cost of providing any single chiropractic service to its enrollees.

MANDATE	DESCRIPTION
Dental care – anesthesia and hospital care	Coverage for administration of general anesthesia and hospital charges for dental care provided to the following covered persons: • A child under the age of five; • A person who is severely disabled; or • A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided. In addition, plans must cover the administration of general anesthesia and hospital or office charges for treatment rendered by a dentist, regardless of whether the services are provided in a participating hospital or surgical center or office.
Diabetes – equipment, supplies and self-management training *Required offer of coverage*	Issuers must *offer coverage* for all physician-prescribed medically appropriate and necessary equipment, supplies and self-management training used in the management and treatment of diabetes. This coverage must include persons with gestational, type I or type II diabetes. These services cannot be subject to any greater deductible or copayment than any other health care service provided by the plan.
Early intervention services for children	Coverage for early intervention services for children from **birth to age three** who are identified as eligible for services under the federal Individuals with Disabilities Education Act (Part C). This coverage is limited to **$3,000 for each covered child per calendar year**, with a **maximum of $9,000 per child**. "Early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology devices. This coverage cannot be subject to any greater deductible, copayment or coinsurance than other similar health care services provided by the plan.
Eating disorders	Coverage for the diagnosis and treatment of eating disorders (as required under Missouri's benefit mandate for mental health coverage).
Emergency services	Coverage for emergency services necessary to screen and stabilize an enrollee, as determined by the treating emergency department health care provider, without requiring prior authorization of these services.
Hearing aids for certain children	Coverage for all hearing aids to children under 18 years of age who receive MO HealthNet benefits.
Immunizations for children	Coverage for immunizations of a child from **birth to five years of age** (as provided in regulations issued by the Missouri Department of Health and Senior Services). This coverage cannot be subject to any deductible or copayment limits.
Lead testing *Required offer of coverage*	Issuers must *offer coverage* for testing pregnant women for lead poisoning and for all testing for lead poisoning authorized by state law, including regulations issued by the Missouri Department of Health and Senior Services. This coverage cannot be subject to

MANDATE	DESCRIPTION
	any greater deductible or copayment than any other health care service provided by the plan
Mammography	Coverage for low-dose mammography screening for any nonsymptomatic woman at the following intervals (at a minimum): • A baseline mammogram for women age 35-39, inclusive (without referral from a primary care provider or other physician); • A mammogram every year for women age 40 and over (without referral from a primary care provider or other physician); • A mammogram every year for any woman deemed by a treating physician to have an above-average risk for breast cancer, in accordance with the American College of Radiology guidelines for breast cancer screening. In addition, coverage for: • Any additional or supplemental imaging deemed medically necessary by a treating physician for proper breast cancer screening or evaluation, in accordance with applicable American College of Radiology guidelines; and • Ultrasound or magnetic resonance imaging services, if determined by a treating physician to be medical necessary for the screening or evaluation of breast cancer for any woman deemed by the treating physician to have an above-average risk for breast cancer, in accordance with American College of Radiology guidelines for breast cancer screening. This coverage must be at least as favorable and subject to the same dollar limits, deductibles, and copayments as other radiological examinations. Providers of low-dose mammography screening must be reimbursed at rates accurately reflecting the resource costs specific to each modality, including any increased resource cost of breast tomosynthesis. Plans that are issued or renewed on or after **Jan. 1, 2024**, and that cover diagnostic breast examinations, supplemental breast examinations, and the coverage required above, or any combination of such coverages cannot impose any cost-sharing requirements with respect to the coverage. For high deductible health plans that are compatible with HSAs, the cost-sharing requirements only apply after a covered person's deductible has been satisfied for the year.
Mastectomy – prosthetic devices and reconstructive surgery	Coverage for prosthetic devices or reconstructive surgery necessary to restore symmetry as recommended by the oncologist or primary care physician for the patient in connection with a mastectomy. This coverage must be subject to the same deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits with the exception that no time limit can be imposed for the receipt of prosthetic devices or reconstructive surgery.

MANDATE	DESCRIPTION
Maternity benefits	Plans that provide maternity benefits must provide coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and her newly born child. A shorter length of hospital stay for services related to maternity and newborn care may be approved if: • A shorter hospital stay meets with the approval of the attending physician after consulting with the mother; and • The plan provides coverage for post-discharge care to the mother and her newborn. This coverage cannot be subject to any greater deductible or copayment than other similar health care services provided by the plan.
Mental health coverage	Coverage for mental health conditions, which include any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (including chemical dependency). The plan cannot impose any rate, term or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits must be comprehensive for coverage of all health conditions, whether mental or physical. Plans that provide coverage for mental health conditions must meet the requirements of the federal Mental Health Parity and Addiction Equity Act.
Newborn hearing screening	Coverage for newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification. This coverage cannot be subject to any greater deductible or copayment than other similar health care services provided by the plan.
Orally administered anticancer medications	Plans that cover cancer treatment must cover prescribed orally administered anticancer medications on a basis no less favorable than intravenously administered or injected anticancer medications. This coverage cannot be subject to any prior authorization, dollar limit, copayment, deductible or other out-of-pocket expense that does not apply to intravenously administered or injected anticancer medication. However, a plan that limits participant cost-sharing to no more than **$75 per 30-day supply** (as adjusted for inflation) for any orally administered anticancer medication will comply with this requirement. For high deductible health plans that are compatible with health savings accounts (HSAs), the cost-sharing requirements only apply after a covered person's deductible has been satisfied for the year.
Organ donors	A person’s status as a living organ donor cannot be the sole factor in the offering, issuance, cancellation, price, or conditions of an insurance policy, nor in the amount of coverage provided.
PKU formula and low-protein modified food products	Coverage for formula and low protein modified food products recommended by a physician for the treatment of a patient with phenylketonuria or any inherited disease of amino and organic acids who is less than **six years of age**. This coverage may be subject to the same deductible as similar covered health care services, a reasonable coinsurance or

MANDATE	DESCRIPTION
	copayment (which cannot be greater than 50% of the cost of the formula and food products), and an annual benefit maximum of not less than $5,000 per covered child.
Physical and occupational therapy – cost-sharing	Cannot impose a copayment or coinsurance percentage for services rendered by a licensed physical therapist or licensed occupational therapist, for services that require a prescription, that is greater than the copayment or coinsurance percentage charged for the services of a licensed primary care physician for an office visit.
Prescription drugs – one copayment for prescribed dosage	If a covered prescription drug is prescribed in a single dosage amount and the particular prescription drug is not manufactured in this single dosage amount and requires dispensing in a combination of different manufactured dosage amounts, the plan can only impose one copayment for the dispensing of the combination of manufactured dosages that equal the prescribed dosage for the drug. This copayment requirement does not apply to prescriptions in excess of a one-month supply.
Prescription eye drop refills	Plans that cover prescription eye drops must cover the refilling of an eye drop prescription prior to the last day of the prescribed dosage period without regard to a coverage restriction for early refill of prescription renewals as long as the prescribing health care provider authorizes the early refill and the plan is notified. This coverage cannot be subject to any greater deductible or copayment than other similar health care services provided by the plan.
Prosthetics *Required offer of coverage*	Must *offer coverage* for prosthetic devices and services, including original and replacement devices, as prescribed by a physician acting within the scope of his or her practice. The benefit amount cannot be less than the annual and lifetime benefit maximums applicable to the basic health care services required to be provided under the plan. If the plan does not include any annual or lifetime maximums applicable to basic health care services, the amount of the benefit for prosthetic devices and services cannot be subject to an annual or lifetime maximum benefit level. Any copayment, coinsurance, deductible and maximum out-of-pocket amount cannot be more than the most common amounts applied to the basic health care services required to be provided under the plan.
Speech and hearing disorders *Required offer of coverage*	Must *offer coverage* for the necessary care and treatment of loss or impairment of speech or hearing subject to the same durational limits, dollar limits, deductibles and coinsurance factors as other covered services.
Telehealth	Cannot deny coverage for a health care service on the basis that it is provided through telehealth if the same service would be covered if provided through face-to-face diagnosis, consultation or treatment. Telehealth services cannot be subject to any copayment, coinsurance or deductible amount, or any policy year, calendar year, lifetime or other durational benefit limitation or maximum for benefits or services that is not equally imposed upon all services covered under the plan. A plan may limit coverage for

MANDATE	DESCRIPTION
	health care services that are provided through telehealth to health care providers that are in a network approved by the plan or the health carrier.
Women's health services	Plans must provide the following health services for women: • Direct access to the services of a participating obstetrician, participating gynecologist or participating obstetrician/gynecologist of her choice within the provider network for covered services. Plans cannot impose additional copayments, coinsurance or deductibles upon any enrollee who seeks or receives these health care services, unless similar additional copayments, coinsurance or deductibles are imposed for other types of health care services received within the provider network. • Services related to diagnosis, treatment and appropriate management of osteoporosis for individuals with a condition or medical history for which bone mass measurement is medically indicated. This coverage may be subject to the same deductibles, coinsurance and other limitations as apply to other covered services.

Provider Mandates

MANDATE	DESCRIPTION
Advance practice nurse	Must reimburse services provided by an advance practice nurse if those services are within the scope of practice of the nurse.
Chiropractor	*Nondiscrimination mandate* – Cannot limit an insured's full freedom of choice to select any of these licensed health care providers for covered services that are within their scope of practice.
Dentist	
Pharmacist or pharmacy	
Physician	
Podiatrist	
Psychologist	
Optometrist	*Nondiscrimination mandate* – Cannot limit an insured's full freedom of choice to select any of these licensed health care providers for covered services that are within their scope of practice.
Surgeon	

Person Mandates

MANDATE	DESCRIPTION
Adopted children	Must cover adopted children of the insured, subscriber or enrollee on the same basis as other dependents. This coverage is effective from: • The date of birth if a petition for adoption is filed within 30 days of the birth; or

MANDATE	DESCRIPTION
	• The date of placement if a petition for adoption is filed within 30 days of the child's placement.
Continuation coverage	Must provide continuation coverage for covered employees, spouses and dependent children in the same manner as the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended. Special continuation coverage rules for spouses (and their eligible dependent children) apply to surviving and divorced spouses who are age 55 or older at the time their coverage under federal COBRA would expire. Spouses who are eligible for the special continuation coverage rules may elect to continue coverage for themselves and any eligible dependent children until age 65 under certain conditions.
Dependent child	Plans cannot deny a dependent child's enrollment on the grounds that: • The child was born out of wedlock; • The child is not claimed as a dependent on the parent's federal income tax return; or • The child does not reside with the parent or in the insurer's service area.
Disabled children	Must provide coverage to a dependent child past the plan's limiting age for a child that is (and continues to be) both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the certificate holder for support and maintenance.
Newborn child	Plans that cover family members must cover a newly born child of an enrollee from the moment of birth. This coverage must consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the plan may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the health carrier within 31 days after the date of birth in order to have the coverage continue beyond the 31-day period.